Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

IRVING COPPELL SURGICAL HOSPITAL
400 W INTERSTATE HWY 635
IRVING TX 75063-3718

Respondent Name
ARCH INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-1701-01

MFDR Date Received
January 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Billed at 130% with implants at cost and 10% mark up; not paid according to Medicare Guidelines."

Amount in Dispute: $5,402.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider Requested payment at 200% of APC. Did not request Separate Reimbursement for implants please see attached."

Response Submitted by: Arch Insurance Co. 300 S. State Street, Syracuse, New York 13702

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 10, 2010	Outpatient Hospital Services	$5,402.20	$5,377.93

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 217 – THE CHARGES HAVE BEEN DISCOUNTED PER REVIEW BY QMEDTRIX'S BILLCHEK SERVICE. FOR QUESTIONS REGARDING THIS ADJUSTMENT, PLEASE CALL QMEDTRIX AT 1-800-833-1993.

- 97 – PYMNT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SRVC/PX. INCLUDED IN GLOBAL REIMBURSEMENT. REIMBURSEMENT IS BEING WITHHELD AS THIS PROCEDURE IS CONSIDERED INTEGRAL TO THE PRIMARY PROC BILLED.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables in accordance with subsection (g). Review of the submitted documentation finds as follows:
   - The requestor submitted a copy of an initial medical bill, dated August 26, 2010, stamped "130% OF APC PLUS COST + 10% OF IMPLANTS."
   - The respondent asserts that "Provider Requested payment at 200% of APC. Did not request Separate Reimbursement for implants please see attached."
   - The respondent submitted a copy of a rebill, dated September 14, 2010, stamped "200% OF APC EXPECTED."
   - The requestor submitted a copy of the request for reconsideration letter, which states "We are requesting 130% of Medicare APC with implant consideration."
   - The requestor submitted a copy of the request for reconsideration bill, dated November 11, 2010, stamped "130% OF APC PLUS COST + 10% OF IMPLANTS."
   - Documentation was found to support that the health care provider included with the billing a certification of the actual cost of the implantables in accordance with the requirements of §134.403(g)(1).

   After thorough review of the documentation submitted in this dispute, based on the preponderance of evidence, the Division concludes that separate reimbursement for implantables was requested in accordance with subsection (g). Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $13,472.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 28322 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0056, which, per OPPS Addendum A, has a payment rate of $3,540.55. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,124.33. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of $2,067.19. The non-labor related portion is 40% of the APC rate

or $1,416.22. The sum of the labor and non-labor related amounts is $3,483.41. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.242. This ratio multiplied by the billed charge of $17,435.00 yields a cost of $4,219.27. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $3,483.41 divided by the sum of all APC payments is 39.75%. The sum of all packaged costs is $933.52. The allocated portion of packaged costs is $371.07. This amount added to the service cost yields a total cost of $4,590.34. The cost of these services exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $3,483.41. This amount multiplied by 130% yields a MAR of $4,528.43.

- Procedure code 28322 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0056, which, per OPPS Addendum A, has a payment rate of $3,540.55. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,124.33. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of $2,067.19. The non-labor related portion is 40% of the APC rate or $1,416.22. The sum of the labor and non-labor related amounts is $3,483.41. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $1,741.71. This amount multiplied by 130% yields a MAR of $2,264.22.
- Procedure code 28322 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0056, which, per OPPS Addendum A, has a payment rate of $3,540.55. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,124.33. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of $2,067.19. The non-labor related portion is 40% of the APC rate or $1,416.22. The sum of the labor and non-labor related amounts is $3,483.41. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $1,741.71. This amount multiplied by 130% yields a MAR of $2,264.22.
- Procedure code 28322 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0056, which, per OPPS Addendum A, has a payment rate of $3,540.55. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,124.33. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of $2,067.19. The non-labor related portion is 40% of the APC rate or $1,416.22. The sum of the labor and non-labor related amounts is $3,483.41. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $1,741.71. This amount multiplied by 130% yields a MAR of $2,264.22.
- Procedure code 28470 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0129, which, per OPPS Addendum A, has a payment rate of $111.73. This amount multiplied by 60% yields an unadjusted labor-related amount of $67.04. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of $65.24. The non-labor related portion is 40% of the APC rate or $44.69. The sum of the labor and non-labor related amounts is $109.93. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $54.97. This amount multiplied by 130% yields a MAR of $71.46.
- Procedure code L8699 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code L8699 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code L8641 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code L8641 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code L8641 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code L8641 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "2.0 PF Pin 14mm" with a cost per unit of $137.00 at 2 units, for a total cost of $274.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "OP-1 IMPLANT" with a cost per unit of $5,000.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "2.7 Quarter Tubular Plate 5 hole" with a cost per unit of $415.00 at 4 units, for a total cost of $1,660.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "2.7 TMT Fasiar Plate" with a cost per unit of $715.00;
   - "IMPLANT, NOT OTHERWISE SPECIFIED" as identified in the itemized statement and labeled on the invoice as "ILIAC CREST WEDGE (ACF) 10-12mm" with a cost per unit of $848.00 at 4 units, for a total cost of $3,392.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "Cannulated Screw System 4.00mm x 24.0mm" with a cost per unit of $120.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "Cannulated Screw System 4.00mm x 28.0mm" with a cost per unit of $120.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "2.7x14 cortical screw" with a cost per unit of $23.00 at 2 units, for a total cost of $46.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "2.7x22 locking screws" with a cost per unit of $127.00 at 2 units, for a total cost of $254.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "2.7x24 locking screws" with a cost per unit of $127.00 at 2 units, for a total cost of $254.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "2.7x18 locking screws" with a cost per unit of $127.00 at 4 units, for a total cost of $508.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "2.7x30 locking screws" with a cost per unit of $127.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "2.7x14 locking screws" with a cost per unit of $127.00 at 5 units, for a total cost of $635.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "2.7x20 locking screws" with a cost per unit of $127.00 at 2 units, for a total cost of $254.00;
   - "IMPLANT ,NOS" as identified in the itemized statement and labeled on the invoice as "2.7x16 locking screws" with a cost per unit of $127.00.

   The total net invoice amount (exclusive of rebates and discounts) is $13,486.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,348.60. The total recommended reimbursement amount for the implantable items is $14,834.60.

5. The total allowable reimbursement for the services in dispute is $26,227.16. This amount less the amount previously paid by the insurance carrier of $20,849.23 leaves an amount due to the requestor of $5,377.93. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $5,377.93.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $5,377.93, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.